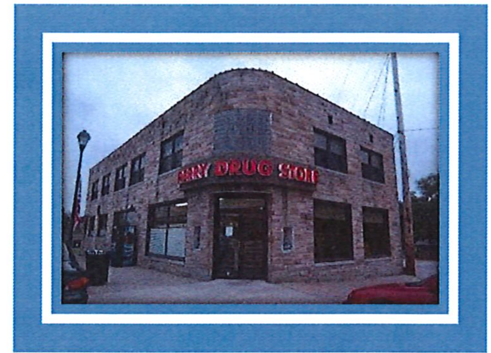

AUTHORIZATION FOR COVID-19 VACCINE ADMINISTRATION 2021

RISKS AND POSSIBLE SIDE EFFECTS: Injection site pain, swelling or redness, tiredness, headache, muscle pain, chills, joint pain, fever, nausea, feeling sick, swollen lymph nodes, severe allergic reactions

PLEASE ANSWER THE FOLLOWING QUESTIONS	**Circle One**	
1. Have you had a severe allergic reaction after a previous dose of vaccine?	Yes	No
2. Have you had a severe allergic reaction to any ingredient of this vaccine?	Yes	No
3. Do you currently have an elevated temperature, acute respiratory or other active illness or infection	Yes	No
4. Have you ever had a severe allergic reaction to the flu vaccine?	Yes	No
5. Do you have a bleeding disorder or are you on a blood thinner?	Yes	No
6. Are you pregnant or plan to become pregnant?	Yes	No
7. Are you breast feeding?	Yes	No
8. Are you immunocompromised or an a medicine that affects your your immune system?	Yes	No

I have read and received the Fact Sheet for Recipients regarding the Emergency Use Authorization (EUA) of the Pfizer COVID-19 Vaccine to prevent Coronavirus Disease (COVID-19). I have had the opportunity to ask questions to my satisfaction prior to consent. I have also read the above consent. I understand the benefits and risks of COVID-19 vaccination and request/authorize the administration of the Vaccine.

______________________________ ____________________________________

Print Patient Name Signature/Date (Patient or Parent/Guardian if under 18)

Parent/Guardian (under 18 years of age)____

Address____ZIP Code____________

Phone Number____

Date of Birth ____________ Age___ Gender___ Dose #1_____ Dose #2______Dose #3_____

__________________ Pfizer ______________________ N/A _________ /IM __________

Date of Vaccination Manufacturer/ Lot number/ Expiration Dose

________________________ Fact Sheet for recipients given: 12/2020

Site: IM RD LD

Administered by:____

PLEASE ATTACH A COPY OF ALL INSURANCE CARDS